POC approved 4/1/08 mstharlee, HSS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3496ASC	A. BUILDING _____ B. WING _____	03/19/2008

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SEVEN HILLS SURGERY CENTER LLC	876 SEVEN HILLS DRIVE HENDERSON, NV 89052

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A 00	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a focused State Licensure survey conducted at your facility on 3/19/07. The survey was conducted using the Nevada Administrative Code (NAC) 449, Surgical Centers for Ambulatory Patients. Findings and conclusions of any investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	A 00		
A 10	NAC 449.980 Administration The governing body shall ensure that: 7. The center adopts, enforces and annually reviews written policies and procedures required by NAC 449.971 to 449.996, inclusive, including an organization chart. These policies and procedures must: (a) Be approved annually by the governing body. This Regulation is not met as evidenced by: Based on observation, policy review and staff interviews on 3/19/08, the governing body failed to ensure that policies on the processing of instruments and their sterilization were developed, failed to update the policy on the processing of endoscopic equipment, and failed to ensure current policies on operating room attire were enforced. The findings include: The administrator reported at 7:30AM the facility	A 10	A 10 The Policy Committee, consisting of 1 staff member from each department and a chairperson, will meet April 8, 2008 to review the facility policy manuals. The chairperson of this committee is directed to meet with this committee until all policies within the organization have been reviewed / revised within the next month. The Board of Managers will work closely with this committee to ensure that the final review and sign off is completed. This is a yearly project that will begin 6 months before the review dates come to term. The Administrator and the Chairperson of this committee will share dual responsibility to see this is accomplished.	3/28/08

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A 10	Continued From page 1 followed the standards of practice of the Association of Perioperative Registered Nurses (AORN). On 3/19/08 from 1:30 PM to 2:00 PM, the anesthesiologist providing care to the patient in operating room #1 was observed wearing a dark blue fleeced zippered jacket over his surgical scrub attire. The anesthesiologist was observed wearing a dark blue fleeced zippered jacket while providing care to another patient at another facility on 3/18/08. Review of the facility policy entitled Attire in the Operating Room, revealed that all personnel entering semi-restricted and restricted areas of the surgical suite shall be in operating room attire consisting of standard multi-use fabric or limited-use non-woven pantsuits and a low-lint surgical hat or hood. All reusable attire shall be laundered after each use, by a laundry facility approved and monitored by the facility. At 3:45 PM, the facility administrator confirmed that no one was allowed to wear personal clothing in the operating rooms over the approved surgical attire provided by the facility. The facility had a policy on operating room attire, but the policy was not enforced. The policy and procedure manual was reviewed regarding the washing and sterilization of instruments and instrument trays. No such policies were located. The only policies regarding instruments found were titled Flash Sterilization, High Level Disinfection of Endoscopes and Endoscopic Equipment Preparation and Inspection.	A 10	Letter sent on March 26th, 2008 to the anesthesiologist responsible for the attire policy breach from the Managing Partner on behalf of the Board of Managers. This letter is attached. Also attached is a memo to OR staff, physicians and Allied Health Professional regarding our attire policy, their responsibility to follow policy, and our zero tolerance for those who breach the policy.	3/28/08

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A 10	Continued From page 2 The administrator reported at 3:30PM that the facility did not have policies that outlined how the different instruments were to be washed or sterilized. AORN 2006 Standards, Recommended Practices and Guidelines regarding sterilization indicated that policies and procedures for sterilization processes should be developed, reviewed periodically and readily available in the practice setting. The governing body had not adopted policies regarding how different instruments were to be washed or sterilized. The policy titled High Level Disinfection of Endoscopes was reviewed. The policy was for a manual method of processing endoscopes in which the scopes were to be immersed in a high level disinfectant for twenty minutes and then rinsed with sterile water. All non-immersible parts were to be cleaned with water and detergent and then wiped with 70% alcohol. The room where endoscopes were processed was inspected and the cleaning process was observed. The room contained an Olympus automatic disinfection unit that did not require submersing endoscopes in a high level disinfectant and rinsing with sterile water. The governing body had not updated the policy regarding the disinfection of endoscopes. Severity: 2 Scope: 3	A 10	Newly created and approved by the Board of Managers are the following policies; Instrument Decontamination and Sterilization Processes, Pre-Vac Sterilization Policy, and STERAD Sterilization Procedure. These policies will be handed out to each staff member of the operating room and CS department, the staff will review and sign a training roster that they have read and fully understand the policy. A copy of the staff in-service roster will go to the OR charge and another copy will be placed in the primary In-service Training Book in the Administrator's office. The approved revised policy on Disinfection of Endoscopes with the Olympus DSD-201 Reprocessor is attached. All staff will be required to read the new policy and sign a training roster. This is the policy that has been in practice since the facility opened so additional training will not be required.	3/28/08 3/28/08
A152	NAC 449.9895 Sterilization 2. If these materials are sterilized on the	A152		

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A152	Continued From page 3 premises, the process of sterilization must be supervised by a person who has received specialized training in the operation of that process, including training in methods of testing to verify the efficiency of the process. This Regulation is not met as evidenced by: Based on record review and interviews on 3/18/08, the facility failed to ensure that 2 of 2 lead instrument technicians had evidence of training regarding the processing of surgical instruments. Findings include: The facility employed three instrument technicians. The newest technician was employed in January of 2008. The male technician reported at 8:00AM that he and another technician were primarily responsible for the processing of instruments, not the new employee. The employee files for the two employees primarily responsible for processing instruments were reviewed. Neither file contained evidence they had received specialized training regarding the processing of surgical instruments. The male technician reported at 2:30PM that he had taken a course and had the certificate, but it was at home and not in his employee file. The administrator stated at 3:30PM she thought the second technician had received training, but had not asked the employee for proof of that training. Severity: 1 Scope: 3	A152	Training documents are attached for the two central processing technicians employed at this facility. The documents address the specific training in the role of a central processing technician which includes sterilization practices, quality monitoring of sterile indicators, wrapping and packaging supplies, and operation of various types of sterilizers and washers.	3/28/08

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A154	Continued From page 4	A154		
A154	NAC 449.9895 Sterilization 4. The efficiency of the method of sterilization used must be checked not less frequently than once each month by bacteriological tests. Records of the results of these tests must be maintained by the center for at least 1 year. This Regulation is not met as evidenced by: Based on record review and interview on 3/19/08, the facility failed to run biological tests on 1 of 3 flash autoclaves. Findings include: The facility was equipped with one primary autoclave and three flash autoclaves. An instrument technician was interviewed at 9:00AM about the STAT IM 5000 flash autoclave. The technician stated that dental drills and diamond blade knives were primarily run in this flash autoclave. The technician reported he ran biological tests in all of the other autoclaves except this unit. The technician stated that only steam indicators and not biological tests were run to verify if the instruments were properly sterilized. The STAT IM 5000 manual was reviewed. The manual indicated that indicators should be run with each load and biological sterility indicators should be run periodically as an independent means of verifying correct operation of the unit. The policy titled Flash Sterilization was reviewed. The policy indicated that biological indicators were to be run daily on the flash sterilizers. The administrator reported at 3:30PM she would not allow staff to run instruments in the flash autoclave until a biological test was completed.	A154	Approved (5/31/07) policy on Biological Monitoring of Steam Sterilizers was revised on 3/28/08 to include the STAT*IM* 5000 and approved by the Board of Managers. Policy will be given to staff for mandated review and signature on the in-service training log. Information from the Regulatory Affairs Department From Sci Can is attached. This information addresses the proper biological to be run in the STAT*IM 5000*. Our present policy on Biological Monitoring was revised to include this information, which is attached.	3/27/08 3/27/08

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A154	Continued From page 5 Severity: 2 Scope: 3	A154		
A161 SS=F	NAC 449.9902 Emergency Equipment/Supplies 1. An ambulatory surgical center must be equipped with: (a) A cardiac defibrillator; (b) A tracheostomy set; and (c) Such other emergency medical equipment and supplies as are specified by the members of the medical staff. This Regulation is not met as evidenced by: Based on observation and interviews on 3/19/08, the facility did not have a tracheostomy set. Findings include: The difficult airway cart was inspected. The cart did not contain a tracheostomy set. The cart did contain a Nu-Trake Emergency Cricothyrotomy kit manufactured by Bivona Medical Technologies. This kit contained a large bore needle, known as a cricoid needle. This needle was to be inserted into the neck at the cricoid to open an obstructed airway in an emergency. This procedure is not considered a tracheostomy. The manufacture was contacted about the "Nu-Trake" kit. An operations supervisor stated that the "Nu-Trake" was a cricothyrotomy device and not considered a tracheostomy set. An acting nurse manager and an instrument technician at the facility reported at 2:30PM the facility did not have a tracheostomy set as required by the regulation. Severity: 2 Scope: 1	A161	Attached is the order confirmation submitted by SHSC for the purchase of a disposable tracheostomy tray with tracheostomy tubes. This will place us in compliance with the state regulation. This item will be placed on the difficult airway cart.	3/27/08

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A238 SS=D	NAC 449.9843.4 Construction Compliance NAC 449.9843 Compliance with standards of construction. 4. An ambulatory surgical center shall comply with all applicable: (a) Federal and state laws; (b) Local ordinances, including, without limitation, zoning ordinances; and (c) Life safety, environmental, health, fire and local building codes. If there is a difference between state and local requirements, the more stringent requirements apply. This Regulation is not met as evidenced by: Based on observations and interviews on 3/19/08, the facility failed to make repairs in the decontamination room after a leak. Findings include: The decontamination room was inspected at 8:00AM. A large ceiling tile located directly over a cart in which dirty instruments were laying was missing. An instrument technician reported at 9:00AM there was a leak about a month ago that damaged many of the ceiling tiles. The ceiling tiles were replaced except for the missing tile. The technician stated that since a hard wired smoke detector was mounted in the damaged ceiling tile, the repairmen needed to cut a new ceiling tile to incorporate the smoke detector.	A238		

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A238	Continued From page 7 The technician stated the repairmen did not have the equipment to cut the new ceiling tile the day of the repair and left without replacing it. The administrator reported at 3:30PM she was aware that the repairmen did not replace the ceiling tile and she failed to follow-up on the repair work. She reported she would have the ceiling tile replaced by the end of the day. Severity: 2 Scope: 1	A238	After the flood, apparently the repairman did not follow through with the last ceiling tile and there was no follow through on the part of the center (Administrator) to see this was completed. However, when discovered, a different repair company was called the day the survey took place and it was completed before the survey team did the summation conference. Attached is a picture of the repaired ceiling, and an invoice for the repair.	3/19/08

Carla Brecken RN COR

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